STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE COMMISSIONER

6 HAZEN DRIVE CONCORD NH 03301-6505
603-271-4334

Harry H. Bird, M.D.
Commissioner

AGREEMENT BETWEEN THE COMMISSIONER OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

and

THE DIVISION OF HUMAN SERVICES, THE DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL SERVICES and THE DIVISION OF PUBLIC HEALTH SERVICES

for

UTILIZATION CONTROL OF LONG TERM CARE FACILITIES

An agreement between the Commissioner of the Department of Health and Human Services, the Division of Public Health Services (DPHS), and the Division of Human Services (DHS), and the Division of Mental Health and Developmental Services (DMHDS).

I. PURPOSE

a. In that the Commissioner of the Department of Health and Human Services is responsible for the Medicaid Program, specifically, the demonstration that the State has a satisfactory and effective program of control over the utilization of inpatient institutional services, the objective of this agreement is to define the administrative management guidelines for the various components relative to the Validation Survey and the submission of the HCFA-41, Quarterly Showing.

b. This agreement delineates the responsibilities of the Division of Human Services, the Division of Mental Health and Developmental Services, the Division of Public Health Services, and the Office of the Commissioner.

II. RESPONSIBILITIES

a. DIVISION OF HUMAN SERVICES (DHS)

1. DPHS/BHFA will call the Long Term Care Supervisor or designated staff person at DHS/OMS one week prior to the on-site review of the swing bed hospital or DHS nursing facility for the mentally retarded and request an alphabetical listing of the residents to be reviewed.

2. DHS will review the alphabetical listing for the facility requested, update if appropriate, and complete an interdepartmental memo assuring that the residents listed are to be reviewed by DPHS. The memo will be signed by the Long Term Care Supervisor or designated staff person assuring the completeness of the list. This memo will be delivered to DPHS/BHFA, either on the day requested or within one working day.

3. One the first day of the on-site review at the facility, the Inspection of Care team will compare the list in the memo and the current Medicaid census, which has been provided by the facility.

4. If there are any discrepancies in these two lists, DPHS/BHFA contact the Long Term Care Supervisor or designated staff person by telephone. DHS/OMS will reconcile the lists with current referrals, recent Prior Authorizations and verify valid recipients. DHS/OMS will provide DPHS with the corrected list within the timeframes requested.

5. One or two days prior to the scheduled exit interview, DHS/OMS will provide DPHS/BHFA with a list of any additional recipients who have entered the system since the start of the review.

6. At least 5 working days after the end of the quarter, DPHS/BHFA shall send a list of names of those recipients reviewed for Inspection of Care during the quarter. DHS/OMS will verify that each Medicaid recipient who should have been reviewed was seen, or that a medical record review was done. DHS/OMS will be responsible for conducting reviews on any missed cases.

7. DHS/OMS will reimburse DPHA/BHFA for Inspection of Care reviews in accordance with the appropriate and approved budget.

b. DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL SERVICES (DMHDS)

1. Promulgates policy that is in compliance with Federal regulations (42 CFR Part 456) regarding utilization control and on-site Inspections of Care for all recipients of Medicaid institutional services rendered in ICF/MR-CPs (Community Programs).

2. Performs evaluation and admission review in conformance with 42 CFR 456.372 on all Medicaid applications/recipients referred for placement in any facility as listed in 11.b.1. and renders level of care determinations. This review and evaluation shall be conducted prior to the authorization of Medicaid payments.

3. Performs a Medicaid continued stay review for each recipient in a ICF/MR-CP at least every six months using the annual inspection of care report and utilization review report alternately.

4. Assigns a length of stay as appropriate.

5. Issues denial notices information concerning the appeals process as appropriate.

6. Appears at fair hearings requested pursuant to the policy, rules and regulations concerning level of care denials rendered by DMHDS.

7. Upon request of DPHS, provides the names of all Medicaid recipients at a specified facility, to be reviewed as part of the Inspection of Care, as defined in Appendix A attached.

8. Requests DPHS to provide information upon request to the appropriate agency as to the observations made during the Inspection of Care review.

9. In accordance with 42 CFR 456.602(g), the Medical Director of DMHDS will be available as needed to consult with DPHS.

10. Prepares the Quarterly Showing (HCFA-41) pages relevant to ICF/MR-CPS.

11. Attends the Validation Survey entrance and exit conferences with HCFA representatives and provides the Validation Survey Team with any additional information requested, as appropriate.

c. DIVISION OF PUBLIC HEALTH SERVICES (DPHS)

1. DPHS will call the designated staff person at DMHDS or DHS approximately one week before the specific IOC is due and request that they provide a list of the individuals that are to be reviewed during the onsite review.

2. DPHS will perform an on-site Inspection of Care (IOC) review of each Medicaid recipient in ICF/MR's and Swing-Bed facilities annually, in accordance with federal regulations (42 CFR Part 456 and the State Medicaid Manual Part 9).

3. The Inspection of Care team shall:

   A. Conduct an entrance conference with the Administrator of the facility or his/her designee:

   B. Have personal contact with and observation of each Medicaid recipient in the facility;

   C. Review each recipient's record;

   D. Conduct an exit conference with the appropriate facility administrative personnel;

E. Issue a written report in accordance with 42 CFR 456.611 to Division of Human Services (DHS) or Division of Mental Health and Developmental Services (DMHDS) for each facility reviewed.

4. DPHS will follow the procedures agreed upon to ensure that each Medicaid recipient identified as residing in the facility to be surveyed is reviewed.

5. DPHS will provide the appropriate agency with a list of all members of the Inspection of Care team and the qualifications of the team members.

6. DPHS will provide information upon request to the appropriate agency as to the observations made during the Inspection of Care review.

7. DPHS will notify the appropriate agency if there are any changes in exit dates for Inspection of Care review.

8. DPHS will submit an annual Inspection of Care budget request to the Office of the Commissioner at the same time as the DPHS Medicare/Medicaid Budget is submitted.

9. DPHS will bill the appropriate agency for Inspection of Care reviews upon completion of the reviews in accordance with the agreed procedures and within the budget approved by the Office of the Commissioner.

d. OFFICE OF THE COMMISSIONER

1. Reviews proposed policy, rules and Title XIX State Plan Amendments for appropriateness and compliance with applicable Federal regulations.

2. Reviews correspondence to HCFA and makes recommendations relative to the Department's position on issues relative to utilization control.

3. Submits the HCFA-41, Quarterly Showing.

4. Represents the Department at Validation Survey entrance and exit conferences and provides the Validation Survey team with additional information requested, as appropriate.

5. Reviews and recommends to the Commissioner the annual Inspection of Care budget request.

6. Recommends to the Commissioner the Department's course of action in the event that the Department is sanctioned by HCFA.

The agreement shall remain in effect until terminated by mutual consent of the parties.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

and

THE DIVISION OF HUMAN SERVICES
THE DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL SERVICES
THE DIVISION OF PUBLIC HEALTH SERVICES

for

UTILIZATION CONTROL ON LONG TERM CARE FACILITIES

5/20/91
Date

Director, Division of Human Services

6/14/91
Date

Director, Division of Mental Health and
Developmental Services

Date

Director, Division of Public Health Services

7/10/91
Date

Medicaid Program Coordinator, Department
of Health and Human Services

7/11/91
Date

Approved by: Commissioner, Department of Health and
Human Services

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Appendix A

1. DPHS will contact the designated staff person at DMHDS, at least one week prior to the scheduled on-site visit of each ICF/MR-CP and request a list of Medicaid recipients to be reviewed at the facility.

2. On the first day of the on-site, the DPHS Inspection of Care Team will advise DMHDS of any discrepancies between the facility's Medicaid census and the list provided by DMHDS and establish the appropriate list of residents to be reviewed.

3. DMHDS will advise DPHS of any additional Medicaid recipients regarding review, that enter the facility during the on-site visit.

4. DPHS will send a list of names of those recipients reviewed for Inspection of Care during the last month of each quarter to DMHDS within five working days after the end of the quarter.

5. DMHDS will verify that all appropriate recipients were reviewed by DPHS and will conduct reviews for any that were missed by the DPHS team.

6. DMHDS will reimburse DPHS/BHFA for Inspection of Care reviews in accordance with budget agreements reviewed and approved by the Commissioner's Office.

JOINT PLANNING, COORDINATION AND IMPROVEMENT OF HEALTH PROGRAMS COORDINATION AGREEMENT

UNDER TITLE V, TITLE X, TITLE XIX AND WIC/CSFP

I. ***HISTORY***

When Title XIX was enacted in 1965, it included a requirement for the development of cooperative arrangements between the state health agency administering Title V Maternal and Child Health programs and the Medicaid agency. In 1970, the enactment of Title X included a requirement for the development of a written agreement between the Family Planning Program and Title XIX. Subsequent amendments to the Social Security Act made the relationship between these two agencies more explicit requiring provisions for Medicaid reimbursement of Title V services, coordination of services, and interagency collaboration. The Omnibus Reconciliation Act of 1989 (P.L. 101-239) expanded and further defined this relationship. The 1990 Title V Maternal and Child Health Services Block Grant emphasized the need to identify children with disabilities and provide them with benefits and coordinated services through existing agencies and funding streams.

The WIC Program's statutory mandate, Public Law 101-11147, the Child Nutrition Act of 1989, requires adjunct income eligibility and coordination of services for WIC applicants who are recipients of Food Stamps, AFDC or Medicaid. In addition, WIC regulations, 264.4(a)(B) and pending CSFP regulations, require the coordination of program operations.

Accordingly, this cooperative agreement has been developed for the following purpose:

II. ***PURPOSE***

The purpose of this agreement shall be to:

A. *Promote the joint planning, development, coordination, monitoring and evaluation of a comprehensive N.H. health care system for women, children and families administered under Title V, Title X, Title XIX, and WIC/CSFP.*

B. *Identify and reduce duplication of services, implement innovative solutions to health care issues, share data, resources and provide clear statements of responsibilities and mutual objectives.*

C. *Develop and implement strategies to assure compliance with federal and state statutes and the efficient and effective use of federal and state resources.*

D. *Simplify the Title V application and referral process and improve child and family access to and utilization of health services.*

E. *Develop and implement procedures for making interagency decisions and for planning, developing and coordinating policies.*

F. *Promote the collaboration, development and implementation of health standards.*

III. ***OBJECTIVES***

A. *Improve the planning, coordination and accountability of health care services for N.H. women, children and children with special*

health care needs by providing accurate and timely information regarding changes in programs, policies and procedures.

B. *Improve Title V, Title X, Title XIX and WIC/CSFP health services programs by simplifying the application and referral process and by eliminating barriers to health services. Assure that all Medicaid-eligible children and women have access to the full range of assessment, diagnostic and treatment services, including those funded by Title V, Title XIX, WIC/CSFP and Title X.*

C. *Improve data collection and utilization of management information systems by coordinating data collection and reporting activities required under the Social Security Act, or as necessary for program management and operation.*

D. *Improve program planning, coordination and operations by establishing formal interagency linkages, defining mutual responsibilities, collaborating in data gathering analysis, reporting and planning on projects of mutual benefit.*

E. *Improve the delivery of health services by participating in joint training, technical assistance and educational activities.*

F. *Improve interagency and interprogram coordination, resource and information sharing through formal standing committees and work groups.*

IV. ***RESPONSIBILITIES***

A. *The Division of Public Health Services and the Division of Human Services shall:*

1. *Designate one or more staff persons to assume responsibilities of liaison and coordination of activities between the Division of Human Services and the division of Public Health Services.*

2. *Participate in joint training education, and technical assistance activities to maintain and improve services and coordination of programs.*

3. *Establish a schedule of periodic meetings as may be required to achieve mutual objectives and activities, improve coordination and ensure proper execution of this agreement.*

B. *Pursuant to P.L. 101-239, the Division of Human Services shall be responsible for providing the following information to the Division of Public Health Services on an annual basis:*

1. *Unduplicated total number of women provided prenatal, delivery, or postpartum care.*

2. *Unduplicated total number of infants, birth to one year of age provided services.*

3. *Total number of service recipients ages 0-21.*

4. *Total number of special health care needs services recipients ages 0-21.*

5. *Total number of SSI recipients under age 16.*

6. *Total number enrolled in Medicaid and CHAP/EPSDT ages 0-21*

TN No. 93-20
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C. The Office of the Commissioner shall be the Medicaid liaison with federal and state officials, and shall provide verbal and written interpretation between HCFA and DPHS concerning Title V, X and WIC/CSFP.

V. **ACTIVITIES FOR ENHANCING INTERAGENCY PLANNING AND COORDINATION**

To promote and support the provision of interagency coordination, planning and delivery of quality health services for children and families, both agencies shall:

1. Exchange information regarding changes in programs, policies, and procedures.

2. Develop and implement policies and procedures for making interagency decision and resolving problems.

3. Identify and eliminate gaps in necessary resources, reduce duplication and identify and eliminate barriers to health services.

4. Collaborate on fee setting for EPSDT visits by Medicaid eligible children, data analysis and rate setting for family planning programs.

5. Share guidance materials, information on new programs and projects of mutual benefit.

6. Collaborate in the development of policies and standards for specialty health services to assure the provision of comprehensive health system.

7. Develop and implement joint outreach activities, including making printed materials available to DHHS District Office personnel.

8. Plan, coordinate and participate in joint training, education and technical assistance activities.

9. Communicate timely information regarding training, education and technical assistance opportunities and resources.

10. Exchange practitioner-specific information, including Medicaid provider status, as required to identify areas with reduced access to health care, and such exchanges for the purpose of requesting federal or state designation of an area as being medically under served or as a health professional shortage area.

VI. **ATTACHMENTS**

Attachment A is a description of 1991-1993 DPHS and DHS cooperative agreement activities undertaken to enhance services funded by title V, X, XIX, and U.S.D.A.

Attachment B is a description of the 1993-1994 DPHS and DHS cooperative agreement activities which will be undertaken to enhance services funded by Title V, X, XIX, and U.S.D.A.

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VII. TERMS AND CONDITIONS

A. Agreement Period

The term of this agreement shall begin on the first day of September, 1993, and will continue thereafter until termination by either party upon 30 days written advance notice to the other.

B. This agreement pertains to all Medicaid State Plan services that are provided by the Division of Public Health Services or by contract agencies.